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U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3160-0104 EXPIRES B/31/88

#### LICENSEE EVENT REPORT (LER)

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At O614 hours on October 27, 1988, sample flow to Radiation Monitor R-15546A was lost, rendering the noble gas monitor and the particulate and charcoal samplers inoperable. The loss-of-flow alarm was acknowledged 17 seconds after it was received; however, flow was not re-established for 160 minutes, nor were compensatory actions taken.

After a review, the Chemistry Effluents group determined that no abnormal release occurred during the 160 minutes, and based dose for the period in question on samples taken before and after that period.

Failure to continuously monitor noble gas, and continuously collect particulate and charcoal samples constitutes a condition prohibited by Technical Specifications and reportable pursuant to 10 CFR 50.73(a)(2)(i)(B).

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3180-0104
EXPIRES. 8-31-88

FACILITY NAME (1)

Rancho Seco Nuclear Generating Station 0 | 5 | 0 | 0 | 3 | 1 | 2 | 8 | 8 --- 0 | 1 | 6 --- 0 | 0 | 0 | 2 | 0 | 0 | 3

## DESCRIPTION OF THE EVENT

TEXT (If more space is required, use additional NRC form 366.4's) (17)

Technical Specifications Table 4.22-1 requires continuous noble gas monitoring, and continuous particulate and charcoal sampling of the Auxiliary Building Grade Level Vent. The sequence of events described below led to a condition contrary to that requirement.

At 0614 hours on October 27, 1988, sample flow to Radiation Monitor R-15546A was lost, rendering the noble gas monitor and the particulate and charcoal samplers inoperable. Loss of sample flow was annunciated on the RM-11 computer display. Seventeen seconds later, the alarm status was acknowledged as indicated on the RM-11 computer display printout. No Control Room log entry was made indicating that R-15546A was not operable, nor was the Shift Supervisor notified. No attempt was mento restore flow for 160 minutes, nor were compensatory actions specified in recunical Specification Table 3.16-1 initiated within one hour. A Radiation Protection Technician performing routine rounds noticed the loss of sample flow to R-15546A and notified Control Room personnel. At 0853 hours, flow was restored and a Potential Deviation from Quality (PDQ) Report was initiated.

A query of Operations personnel was performed to determine who acknowledged the alarm. None of the Operations personnel in the Control Room at the time of the event remember acknowledging the alarm.

The Chemistry Effluents group performed a dose assessment of the event, evaluating releases from the Auxiliary Building Stack and plant operations for the time period in question. Doses have been assigned based on samples taken before and after the event and did not cause an abnormal dose impact.

# PLANT OPERATING CONDITIONS

At the time of the event, the plant was in Hot Shutdown.

## CAUSE OF THE EVENT

Loss of sample flow to R-15546A caused loss of continuous noble gas monitoring and loss of continuous particulate and charcoal sampling.

It is not yet know, why R-15546A lost sample flow. The Independent Investigation/Reviews Group (IIRG) is continuing to investigate. Preliminary investigations indicate little likelihood of discovery of the cause of this event; however, if the cause can be determined, this LER will be updated.

#### METHOD OF DISCOVERY

A Radiation Protection Technician performing routine rounds to record radiation monitor readings noticed the loss of sample flow for R-15546A while reviewing the RM-11 computer display.

NRC Form 366 (6-8-7)		T (LER) TEXT CONTINUATION										U.S. NUCLEAR REQULATORY COMMISSION APPROVED DMS NO. 3150-0104 EXPIRES 8-31-86														
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## IMMEDIATE CORRECTIVE ACTIONS

The Radiation Protection Technician discovering the event notified the Control Room Operator of the condition. The Control Room Operator notified the Shift Supervisor and restored sample flow to R-15546A. A PDQ Report was initiated.

The Chemistry Effluents group performed an assessment of the dose impact of the event.

# PROGRAMMATIC CORRECTIVE ACTIONS

By December 31, 1938, the Operations Department will evaluate policy for use of the RM-11 computer display and implement any appropriate changes. Policy for acknowledging alarms will be reviewed with Operations personnel.

By December 31, 1988, Operations and Maintenance personnel will receive a briefing on the events which led to the event and consequent LER.

By January 13, 1989, the IIRG will perform a root cause investigation to determine the cause of loss of sample flow to R-15546A and any additional corrective actions.

# SAFETY CONSEQUENCES

There were no adverse consequences affecting the health and safet of the public or Rancho Seco employees as a result of this event. No abnormal releases occurred. If an abnormal release had occurred, it would have also been detected on R-15045, the Auxi 'ary Building Stack Monitor.

## PREVIOUS SIMILAR EVENTS

A review of Rancho Seco LERs revealed the following similar events:

Reportable Occurrence 77-4 (No title)
LER 86-03, Containment Purge Unmonitored
LER 86-019, Noble Gas Grab Sample Not Taken in Time Required by the
Technical Specifications



SACRAMENTO MUNICIPAL UTILITY DISTRICT P. O. Box 15830, Sacramento CA 95852-1830, (916) 452-3211
AN ELECTRIC SYSTEM SERVING THE HEART OF CALIFORNIA

CEO 88-364 November 23, 1988

U. S. Nuclear Regulatory Commission Attn: Document Control Desk Washington, DC 20555

Docket No. 50-312
Rancho Seco Nuclear Generating Station
License No. DPR-54
LICENSEE EVENT REPORT 89-16: FAILURE TO CONTINUOUSLY MONITOR AND
SAMPLE THE AUXILIARY BUILDING GRADE LEVEL VENT

Attention: George Knighton

In accordance with the requirements of 10 CFR Part 50.73(a)(2)(i)(B), the Sacramento Municipal Utility District hereby submits Licensee Event Report 88-16.

Members of your staff with questions requiring additional information or clarification may contact Ms. Rita W. Bowser at (209) 333-2935, extension 4522.

Sincerely.

Joseph F. Firlit

Chief Executive Officer

Nuclear

Attachment

cc w/atch: A. D'Angelo, NRC, Rancho Seco

J. B. Martin, NRC, Walnut Creek (2)

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